NARAL
Pro-Choice America Foundation

"No Taxpayer Funding for Abortion Act" (H.R.3):
An Extreme Attack on Women's Access to Abortion Coverage

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Subcommittee on Select Revenue Measures

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Members of the Ways and Means Subcommittee on Select Revenue Measures: I am honored to submit this testimony on behalf of NARAL Pro-Choice America, our state affiliates, and the pro-choice Americans we represent.

Today you are considering the "No Taxpayer Funding for Abortion Act" (H.R.3), introduced by Rep. Chris Smith (R-NJ), a bill that is misleading in its claim that it ends public funding for abortion care. This bill is not about public funding. Regardless of one's view on this issue, federal law is clear: federal funding of abortion is forbidden, except in very narrow circumstances. Instead, this bill is an attempt to reopen the debate on private insurance coverage of abortion and to dismantle entirely the Affordable Care Act. Recognizing the subcommittee's narrow jurisdiction on this legislation, I would like to offer the following analysis, which situates H.R.3's tax provisions within a broader policy context.

Introduced as part of the effort to repeal and replace the health-care law, this bill exposes that anti-choice House leadership's view of "public funding" bears no resemblance to reality. The legislation's true objective is to insert anti-choice politics into the tax code and jeopardize the availability of private insurance coverage for abortion. More sweeping in scope than its name implies, the Smith bill does far more than reinforce existing bans on public funding for abortion care; it launches a radical new anti-choice attack on abortion access.

Imposes Tax Penalties on the Purchase of Abortion Coverage

The Smith legislation interferes with coverage of abortion services within the private-insurance market and makes chaotic changes to tax policy. It does so by imposing tax penalties on small businesses and many individuals who choose private health plans that cover abortion care. (At present, 87 percent of private plans cover abortion services.[1]) In levying taxes on the purchase of plans that include abortion coverage, the Smith bill severely threatens the private market for comprehensive insurance coverage that includes abortion care.

Specifically, the law would:

- Force small businesses to pay taxes on the health benefits they offer their employees if their insurance plan covers abortion care. It does so by eliminating the Small Business Health Tax Credit enacted as part of the health-care law for any small business that provides workers a comprehensive insurance plan including abortion care. As the vast majority of private insurance plans currently cover abortion services,[2] many of the four million small businesses estimated to be eligible for this credit if they provide health care to their workers would be forced to forgo this assistance.[3]

- Restrict the use of private dollars placed in tax-preferred Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). The Smith bill forbids individuals from using

private funds saved in HSAs and FSAs from being used to pay for abortion care, except in extremely limited circumstances.

- Impose tax penalties on many individuals who have high out-of-pocket health-care costs. Current law allows individuals to deduct all health-care expenses that exceed 7.5 percent of their gross income. The Smith bill, however, would make the cost of abortion care non-deductible—even in extreme health circumstances where care can cost tens of thousands of dollars—forcing those individuals who access such care to pay increased taxes.[4]

- Raise taxes for workers who lose their jobs as a result of outsourcing. Under current law, individuals who lose their jobs due to outsourcing are eligible for the Health Coverage Tax Credit, which covers 65 percent of the costs of a qualified health-plan premium. Under the Smith bill, however, any health plan that includes abortion coverage would be disqualified from receiving this tax credit.[5]

The National Women's Law Center (NWLC) quantified the impact that these tax penalties would have on hypothetical individuals and small businesses. Based on the NWLC's analysis:

- A restaurant with 40 half-time employees whose wages totaled $500,000 and health-care costs totaling $240,000 per year would be eligible for a Small Business Health Tax Credit under current law. Under the Smith bill, however, that restaurant's taxes would be raised by $28,000 if its health insurance plan includes abortion coverage.[6]

- A man with a wife and three children loses his job when his manufacturing plant closes and becomes eligible for certain federal assistance, including the Health Coverage Tax Credit. However, under the Smith bill, if his insurance plan covers abortion care, as most plans do, he would be disqualified from this benefit – costing him $9,129.[7]

Imposing benefits exclusions for abortion services will not only raise taxes for businesses that purchase insurance coverage of abortion and individuals who seek abortion care, but it also will jeopardize insurer willingness to offer products that include abortion coverage. Particularly for small-employer plans, insurance companies may be more likely simply to drop abortion coverage from policies than attempt to comply with H.R.3's complex framework. As noted by Prof. Sara Rosenbaum of the George Washington University School of Public Health and Health Services, "a far easier and completely legal strategy for private insurers and plan administrators would be simply to exclude coverage of all abortions from their coverage products…rather than risk a violation of the federal exclusion that in turn would result in the loss of tax-favored treatment for the entire product."[8]

Moreover, newly considering tax benefits to be public funding – as the bills' sponsors propose – throws many tax exclusions into question, logically and legally. For instance, as Rep. Jerrold Nadler (D-NY) has correctly pointed out, classifying tax deductions, credits, or tax-favored status as public funding would require reconsidering the constitutionality of tax benefits

associated with sectarian organizations, given the Establishment Clause's explicit prohibition of public funding of religious activities: "If tax-advantaged private spending is government funding – the entire premise of this bill – then your tax deductable charitable contribution to your church, synagogue, or other religious institution is also government funding – government funding prohibited by the Establishment Clause of the First Amendment."[9]

Revives Core Provision of the Stupak-Pitts Amendment

In an effort to reopen the contentious issue of abortion coverage, the Smith legislation revives the core provision of the failed Stupak-Pitts amendment, and effectively would end abortion coverage for women in state insurance exchanges who use their own, private funds to pay for their insurance**.** The Smith bill makes it highly unlikely that insurance companies will opt to offer abortion coverage in state exchanges: it forbids any plan offering such coverage from accepting even one subsidized customer, forcing insurers to choose between offering their product without abortion coverage to the entire universe of consumers in a state exchange and offering a benefits package that does include abortion services to a small minority of unsubsidized customers. (Because a vast majority of participants in state insurance exchanges will be subsidized,[10] it seems clear which choice insurers are likely to make.) As a result, in addition to women who will pay part, or even most, of their insurance premium with private funds, millions of unsubsidized individuals and small-businesses employees who obtain insurance through a state health-insurance exchange will be denied abortion coverage.

In addition to restricting who may purchase abortion coverage within state insurance exchanges, the Smith bill would impose crippling administrative burdens on plans that wish to cover abortion care. If the Smith bill becomes law, insurance companies that offer abortion coverage—as 87 percent of plans currently do[11]—would face high costs, technical complexities, and onerous administrative requirements.[12]

The bill's purported solution of "preserving" the option of abortion-coverage "rider" policies for women who purchase an exchange-based plan but seek abortion coverage is a false promise. Low-income women who receive insurance subsidies are unlikely to be able to afford a supplemental policy, and women who can afford to purchase riders are unlikely to do so, as unintended pregnancies are by definition unplanned. Moreover, existing data on rider policies suggest that they simply do not work. Information from the five states that ban abortion coverage entirely except by separate rider is not promising. Last year, *The Washington Post* discovered that insurance companies in those states reported a lack of availability and demand for such riders.[13] The implication of these data is that, under the Smith bill, abortion riders will likely not be available to customers.

The combination of imposing tax penalties for purchasing plans that include abortion coverage and banning abortion coverage in state health-insurance exchanges jeopardizes the entire existence of this important reproductive-health benefit. As the state exchanges grow, they will

have a greater effect on the health-insurance industry as a whole, eventually becoming the standard for benefits packages.[14] The Smith bill, if enacted, could have an industry-wide effect, and, over time, cause the elimination of coverage of abortion services for most women – not just those who obtain coverage through a health-insurance exchange.

Recodifies Existing Bans on Abortion Coverage

This extreme proposal also would reinforce long-standing discriminatory bans on publicly funded abortion care by permanently denying low-income women, federal employees, women in the military, and residents of the District of Columbia access to abortion coverage.

Again, current law already bans public funding for abortion care; regardless of one's view of that policy, it is indisputably already the law of the land. The Smith bill writes the bans into permanent law, including the Hyde amendment, a discriminatory restriction that bars low-income women's access to abortion services, except in extreme circumstances. Currently, these various bans are renewed annually in appropriations bills and the annual Defense authorization legislation. The Smith bill would deny permanently coverage to the nearly 18 million individuals insured by Medicaid,[15] the 6.7 million non-elderly and disabled individuals currently enrolled in Medicare,[16] and the 1.5 million American Indians and Alaska Natives who receive health insurance through the Indian Health Service (IHS).[17]

Additionally, the U.S. government offers health benefits plans to eight million federal employees, their dependents, and retirees, 44 percent of which are women.[18] The Smith bill permanently bans abortion coverage for these federal employees and their dependents, even though these workers pay a portion of their health insurance premiums with their own private dollars.

Similarly, the bill also recodifies the ban on abortion care for women in military hospitals overseas, a policy that a majority of members of the Senate Armed Services Committee voted to repeal in 2010, and permanently denies abortion coverage to the nine million individuals who receive health insurance through TRICARE, the military health plan.[19]

Likewise, the Smith bill would permanently deny abortion coverage to Peace Corps volunteers. Of the 7,671 U.S. citizens who are currently volunteers and trainees for the Peace Corps, 60 percent are women.[20] Finally, the Smith bill also reimposes the ban on Washington, D.C.'s ability to use its own local funds to cover abortion services for the 64,500 low-income women currently enrolled in its Medicaid program – an unfair restriction that Congress lifted in 2009.[21]

Overall, the more than 13.5 million adult women who receive health coverage through Medicaid and other government-sponsored programs described above permanently would lose access to abortion coverage, except in incredibly narrow circumstances.[22]

Discriminatory bans on abortion coverage create significant, often insurmountable, obstacles for women seeking abortion care. Low-income women often have difficulty raising the money to pay for abortion services and research indicates that economic barriers often cause them to obtain abortion care two to three weeks later in pregnancy than do wealthier women.[23] This is especially problematic because the cost of abortion care increases the longer the pregnancy continues. Later abortion care, which is already inaccessible to women in many states, ranges into the thousands of dollars, and can pose an insurmountable cost.[24] These burdens disproportionately affect women of color, who, because of the connection between racial discrimination and economic disadvantages, are more likely than white women to be poor, to lack health insurance, and to rely on government health-care programs or plans.[25] Reiterating the abortion-coverage bans in permanent law adds insult to already deeply injurious policies.

Finally, the Smith bill also recodifies the Helms amendment, a policy that denies some of the world's poorest women access to safe abortion care by prohibiting the use of U.S. funds to pay for abortion services in developing countries. Not only would the Smith bill jeopardize the availability of abortion coverage for American women, it would have detrimental international ramifications as well.

Inadequate Exceptions

It should also be noted that the Smith bill excludes any kind of exception that would protect the health of the woman, or provide care in cases of fetal anomaly. While the absence of insurance coverage for abortion care hurts all women, it particularly harms those for whom pregnancy threatens their health. Many women welcome pregnancy at some point in their lives and can look forward to a safe childbirth; however, for some, pregnancy can be dangerous, and abortion restrictions, such as the Smith bill, that do not contain exceptions to protect women's health endanger these women. The Smith legislation would limit access even for women in the most desperate of circumstances, whose care is often the most expensive and the most urgent. For example:

- Vikki Stella, a diabetic, discovered months into her pregnancy that the fetus she was carrying suffered from several major anomalies and had no chance of survival. Because of Vikki's diabetes, her doctor determined that induced labor and Caesarian section were both riskier procedures for Vikki than an abortion. The procedure not only protected Vikki from immediate medical risks, but also ensured that she would be able to have children in the future. [26]

- Jennifer Peterson was 35 and pregnant when she discovered a lump in her breast. Tests showed she had invasive breast cancer. The cancer and its treatment, separate and apart from the pregnancy, were a threat to her health. Her pregnancy posed a significant added threat to her health during the onset and treatment of her cancer. About one in

3,000 pregnant women also has breast cancer during her pregnancy, and for these women, a health exception is absolutely necessary. [27]

- Gilda Restelli was well into her pregnancy when doctors discovered that her fetus had only fragments of a skull and almost no brain. She and her husband had been told by medical experts that their baby had almost no chance of survival after birth. Restelli quit her job, not because she was physically incapacitated, but because she could no longer bear the hearty congratulations of strangers who were unaware of the tragic circumstances surrounding her pregnancy. The Restellis made the agonizing decision to end the pregnancy. [28]

- D.J., a federal employee, was 11 weeks into a wanted pregnancy when she learned that her fetus had anencephaly, meaning that the fetus would never develop a brain. Her doctor provided abortion care at a local hospital. Several months later, she received a bill for $9,000 – and was told her insurance would not cover the costs because, as a federal employee, she was not entitled to insurance coverage for abortion services unless the pregnancy endangered her life.

Reminders of the Bill's Dangerous Intent

Until sponsors were forced to remove these provisions after public outcry, the original version of H.R.3 had two additional extreme and mean-spirited provisions:

First, the bill as introduced would have narrowed the already severely limited rape and incest exceptions that exist in federal law, denying, at minimum, abortion coverage to survivors of statutory rape and any incest survivor 18 years of age or older. Most federal laws that restrict access to abortion services allow exceptions for instances of life, rape, or incest. However, language in the original bill limited these exceptions to include only victims of "forcible rape" and "incest with a minor." This restriction would have applied to all federal programs, affecting not only low-income women in Medicaid, but women in the military and all federal employees, as well.

Additionally, the original version of the Smith bill would have allowed states to refuse coverage for abortion in all cases, even when a woman's life was in danger. Current federal law requires state Medicaid programs to cover abortion in cases where the pregnancy occurred because of rape or incest, or when the woman's life is endangered, and every court that has considered this requirement has upheld it. The original Smith bill, however, would have taken away this already-minimal protection and allowed states to refuse Medicaid coverage for abortion in all cases.

While no longer included in the current version of the bill, these provisions serve as indicators of the sponsors' startling and extreme anti-choice agenda.

Conclusion

The Smith bill represents an extreme new anti-choice agenda that drastically distorts the concept of "public funding." In trying to redefine this term falsely, the Smith legislation jeopardizes the availability of abortion coverage in the new health system and levies harsh financial penalties on businesses that provide their employees comprehensive insurance coverage. The bills' sponsors even attempted to redefine rape and invited states to deny coverage for care to women who would die without it. As has been asserted by Rep. Nadler, the purpose behind H.R.3 is clear: "to use economic coercion to prevent women and families from exercising their Constitutional right…by going after the private insurance and health care markets."[29]

Reasonable lawmakers, even those who may not agree with the pro-choice perspective on the issue of public funding for abortion, should recognize this bill for what it is: a radical departure from the status quo.

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[1] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 2002, Perspectives on Sexual Reproductive Health, 36(2):72-79 (2004).

[2] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 2002, Perspectives on Sexual Reproductive Health, 36(2):72-79 (2004).

[3] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[4] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[5] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[6] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[7] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[8] *H.R.3, the No Taxpayer Funding for Abortion Act: Hearings Before the House Judiciary Subcomm. on the Constitution*, 112th Cong. (2011) (testimony of Prof. Sara Rosenbaum) *at* http://judiciary.house.gov/hearings/pdf/Rosenbaum110208.pdf (last visited March 15, 2011).

[9] *H.R.3, the No Taxpayer Funding for Abortion Act: Mark-Up of H.R.3 by the House Comm. on the Judiciary*, 112th Cong. (2011) (opening statement of Rep. Jerrod Nadler) *at* http://nadler.house.gov/index.php?option=com_content&task=view&id=1620&Itemid=132 (last visited March 14, 2011).

[10] CONGRESSIONAL BUDGET OFFICE, 111TH CONGRESS, Letter to Congressmen Dingell (2009) *at* http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf.

[11] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 2002, Perspectives on Sexual Reproductive Health, 36(2):72-79 (2004).

[12] *See*, Sara Rosenbaum et al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions, at* 25 (Nov. 16, 2009), *at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Feb. 4, 2011).

[13] Peter Slevin, *Insurers report on use of abortion riders*, Washington Post, Mar. 14, 2010.

[14] Sara Rosenbaum et al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions*, *at* 9 (Nov. 16, 2009), *at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Feb. 4, 2011).

[15] Kaiser Family Foundation, "Distribution of the Nonelderly with Medicaid by Age," *State Health Facts* (2009) *at* http://statehealthfacts.kff.org/comparebar.jsp?typ=1&ind=154&cat=3&sub=42 ((last visited Feb. 4, 2011).

[16] Kaiser Family Foundation, "Distribution of Medicare Enrollees by Age," *State Health Facts* (2009) *at* http://statehealthfacts.kff.org/comparebar.jsp?ind=294&cat=6 (last visited Feb. 4, 2011).

[17] Indian Health Service (IHS), *Indian Health Service: Fact Sheet* (Feb. 19, 2002), *at* http://www.ihs.gov/AboutIHS/ThisFacts.asp (last visited Feb. 4, 2011).

[18] U.S. Office of Personnel Management, *The Fact Book, Federal Civilian Workforce Statistics* (2007), 82, *at* http://www.opm.gov/feddata/factbook/ (last visited Oct. 16, 2009).

[19] TRICARE, *What is TRICARE?* (September 2010) *at* http://www.tricare.mil/mybenefit/home/overview/WhatIsTRICARE (last visited Feb. 4, 2011).

[20] Peace Corps, *Peace Corps Fast Facts*, (last modified Jan. 28, 2010), *at* http://www.peacecorps.gov/index.cfm?shell=learn.whatispc.fastfacts (last visited Feb. 4, 2011).

[21] Consolidated Appropriations Act, 2010, P.L. 111-117, 111th Cong. (2009).

[22] Kaiser Family Foundation, "Health Insurance Coverage of Women 19-64," *State Health Facts* (2009) *at* http://www.statehealthfacts.org/comparebar.jsp?typ=1&ind=652&cat=3&sub=178 (last visited Feb. 4, 2011).

[23] Center for Reproductive Rights, *Women's Reproductive Rights in the United States: A Shadow Report* (June 2006).

[24] Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services,* 40 Persp. on Sexual and Reprod. Health 6, 14 (2008).

[25] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *The Reproductive Rights and Health of Women of Color* (2000), at 22.

[26] *Partial Birth Abortion Ban of 1995: Hearing on H.R.1833/S. 939 Before the Senate Comm. on the Judiciary*, 104th Cong. (1995) (testimony of Vikki Stella).

[27] THE NATIONAL CANCER INSTITUTE, *Breast Cancer and Pregnancy, Patient Information* (Sept. 19, 2002), *at* http://www.cancer.gov/cancerinfo/pdq/treatment/breast-cancer-and-pregnancy/patient/ (last visited Feb. 4, 2011).

[28] William Raspberry, *Abortion: A Tough Case*, WASH. POST, Aug. 31, 1998, at A21; Felice J. Freyer, *Hospital Agrees to End Tragic Pregnancy*, PITTSBURGH POST-GAZETTE, Aug. 30, 1998, at A3.

[29] *H.R.3, the No Taxpayer Funding for Abortion Act: Mark-Up of H.R.3 by the House Comm. on the Judiciary*, 112th Cong. (2011) (opening statement of Rep. Jerrod Nadler) *at* http://nadler.house.gov/index.php?option=com_content&task=view&id=1620&Itemid=132 (last visited March 14, 2011).